Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

Integra Specialty Group, P.A.
517 N. Carrier Parkway, Suite G
Grand Prairie, TX 75050

Respondent Name

TRANSPORTATION INSURANCE CO

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-11-2039-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pre-authorized - # 8388238"

Amount in Dispute: $ 13,236.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier filed TDI DWC "PLN-11" dated 07/21/2010 for the alleged injury of 03/18/2009. A Benefit Contested Case Hearing was never requested and the claimant never pursued."

Response Submitted by: Law Offices of Brian J. Judis, 600, N. Pearl, Suite 1450, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 22, 2010 – July 16, 2010	97799-CP, 97032, 97035, 97110, 97112 & 97140	$**13,236.27**	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 relates to MDR-General.
2. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.28 Texas Administrative Code §102.4 set out the rules for Non-Commission Communications.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 9, 2010 and February 8, 2011

- 216 – Based on the findings of a review organization.
- 855-020 – Reimbursement has been denied based upon the recommendation of a PEER REVIEW $0.00
- W1 – Workers Compensation State Fee Schedule Adjustment.
- 930-007 – Physical Medicine/Chiropractic Services rendered beyond $5000.00 Sine DOI.
- 930-011 – Physical Medicine/Chiropractic Services rendered beyond 90 days Since DOI.
- 930-012 – Physical Medicine/Chiropractic Services rendered beyond 15 visits Since DOI.
- 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer. This change to be effective 04/01/2010: Additional verbiage – Note: Refer to the 835 Healthcare Policy Identification Segment, if present.
- 855-019 – UNNECESSARTY TREATMENT $0.00
- 96 – Non-covered charge(s). At least on Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
- 880-024 – NC (NON-COVERED) PROCEDURE, TREATMENT AND/OR SERVICE, PAYMENT DENIED. $0.00
- 219 – Based on extent of injury
- 855-010 – NC (NON-COVERED) PROCEDURE OR SERVICE, PAYMENT DENIED $0.00
- 197 – Precertification/authorization/notification absent.
- 880-139 – Reimbursement has been denied based upon the recommendation of a peer review 100%.
- 880-287 – UNNECESSARY MEDICAL TREATMENT BASED ON ODG 100%.
- 880-155 – DENIED PER INSURANCE: NO PROOF OF PRE-AUTHORIATION PROVIDED.
- 18 – Duplicate claim/service.
- 880 – THE SUBMITTED CHARGE IS A DUPLICATE OF A PREVIOUSLY CHARGE FOR THE SAME DOS, PROCEDURE AND PATIENT UNDER ANOTHER PROVIDER ID. SEE BELOW FOR PREVIOUSLY REVIEWED BILL NUMBER $100.00.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division on <Date received in MFDR>. According to 28 Tex. Admin. Code §133.305(a)(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Tex. Admin. Code §133.305(b) goes on to state, "Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021". The dispute is resolved by the Division of Workers' Compensation pursuant to 28 Tex. Admin. Code §133.307. 28 Tex. Admin. Code §133.307(e)(3)(H) requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals. The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Tex. Admin. Code §141.1. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved as of the undersigned date.
2. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Tex. Admin. Code §133.307

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning liability for the injured employee's workers' compensation claim, compensability of that claim, and/or extent-of-injury issues with that claim have been resolved through the Tex. Labor Code Chapter 410 dispute resolution processes, as required, prior to any medical fee dispute for the services being considered.

Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute and, as a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

9/8/11

Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.